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ABSTRACT

Child abuse and neglect among American Indians is a political, as well as a clinical problem, as the victims belong to one cultural group and health professionls who detect maltreatment generally belong to another. Reluctance to diagnose and report child abuse, although universal, is probably more significant in Indian communities for several reasons: unclear reporting practices, possible unfavorable community reaction to reporting of maltreatment, and absence of effective protection and treatment programs, resulting in negative consequences such as separation of children from families. Although each case of child maltreatment must be assessed individually, some general patterns are: non-Indian health and social workers' misunderstanding of traditional childrearing practices; poverty; cultural change with erosion of social supports; situational stress with ineffective social supports; unparented parents (those raised in boarding schools and foster homes, with poor parental role models); alcoholism; divorce; unusual perceptions of children (psychotic or influenced by mythology); handicapped children; and sexual abuse. Health professionals should work cooperatively with other agencies, communities, and parents to deal with child maltreatment through prevention at three levels: primary (provide education to prevent unwanted pregnancy, enhance parental adjustment to pregnancy/parenthood, facilitate parent/child attachment), secondary (early detection of maltreated children), and tertiary (intervention to minimize handicapping effects of child abuse). (MH)

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CHILD ABUSE AND NEGLECT IN AMERICAN INDIANS

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Introduction

Only since 1961 have Americans become aware of family violence and disintegration, which account for significant morbidity and mortality of children.

The more recent discovery of significant child maltreatment in American Indian communities has created unique problems both for Indian people and for non-Indian health professionals who encounter it with increasing frequency.

The abuse and neglect of a child symbolizes the ultimate failure of the family unit. In Indian tribal cultures, the child is highly valued and occupies a central place within the family. The traditional Indian family includes an extensive kinship network of cousins, aunts, uncles and grandparents who participate actively in childrearing. As a result of bonds formed early, the Indian child's self-concept is strongly tied to his family, clan and tribe.[1] Many tribes were historically nomadic; in times of peril, when a child could not be cared for an intact extended family mobilized effectively to protect children, providing temporary or permanent substitute parents. When the extended family is not intact (as appears increasingly to be the case today), tribes have had to develop legal and social systems to protect children. These rely on available

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resources in: federal, state and tribal governments and local churches. Interactions between these agencies often conflict and skirmishes can obscure the central focus: protection of the maltreated child and restoration of a functioning family unit.

Definition of Child Maltreatment in Native American Communities

When the victims belong to one cultural group (Indian) and the health professionals who detect maltreatment generally belong to another, a potential for misunderstanding exists. On one hand, a culturally acceptable practice may be inappropriately viewed as maltreatment. On the other hand, a truly harmful practice may be overlooked as being "traditional." Korbin proposes a cross-cultural definition of maltreatment, "The idiosyncratic departure from culturally and socially acceptable standards (of childrearing) that results in harm to a child or compromises his/her physical, emotional, cognitive, social or cultural development.[2] Abuse generally refers to acts of commission, where a child is hurt by what the parent/caretaker does (with or without intent). Neglect refers to acts of omission, when a child is hurt by the failure to provide necessary care and protection. (See Table 1).

Some American Indian authors view child maltreatment in political terms, "as the result of social pressures originally outside of the individual and occurring because of institutional pressures exerted by one society on another."[1] They also believe that Indians have been unjustly accused of child maltreatment by non-Indians with resultant inappropriate removal of children and breakup of families. As evidence to support this viewpoint, the Congressional investigation that led to the passage of the Indian Child Welfare Act in 1978 concluded that "a

pattern of discrimination against American Indians is evident in the area of child welfare, and it is the responsibility of Congress to take whatever action is within its power to see that Indian communities and their families are not destroyed."[3] The American Association for Indian Affairs (AAIA) reports that twenty-five to thirty-five percent of all American Indian children have been separated from their families and placed in foster homes, adoptive homes, or institutions such as boarding schools because of "neglect." "In judging the fitness of a particular family, many social workers, ignorant to Indian cultural values and social norms, make decisions that are totally inappropriate in the context of Indian family life, so they frequently observe neglect or abandonment when none exists".[4]

Child maltreatment is thus a political as well as a clinical problem. In 1975 when the author (a non-Indian) first discussed child abuse at the tribal health committee on the San Carlos Apache Reservation, a tribal councilman reacted with disbelief and scorn. From his perspective, the only child abuse was that perpetrated by Anglos (sending children away to non-Indian foster homes, punishing them for speaking their native languages in boarding schools, etc.). However, when details of specific cases were shared, including cases of venereal disease in young children, unexplained fractures in various states of healing, severe malnutrition with rapid catchup growth in hospital, etc., this councilman became an active supporter of community child protection efforts.

How Common is Child Maltreatment Among Indians?

Before 1961 there were essentially no reported cases of child

maltreatment in this country, or for that matter, in the world. By 1976, however, American Humane Society recorded nearly one hundred thousand cases reported per year, or an average 4.3 reports of abuse and neglect per thousand children per year, with a range of one to nineteen per thousand per year among the fifty states.[5]

It is widely believed that child maltreatment is under reported and the true incidence at least ten times the number of cases reported. Reporting depends on public awareness, reporting laws, the availability of family support services, and systems for data collection, all of which are lacking in most Indian communities.

There are three sources of published data on the occurrence of maltreatment in American Indian children. A study on the Navajo Reservation in 1975 disclosed a rate of 13.5 validated cases per thousand children less than nine years of age per year. The ratio of neglect to abuse was six to one, consistent with national estimates of neglect being five to ten times more common then abuse. Deaths attributed to abuse were 0.5%, comparable with national death rates.[6] A study from Cheyenne River, South Dakota (Sioux) reported twenty-six per thousand children per year of child abuse and neglect with a five percent mortality rate (ten times the national rate).[7] American Humane Society reports data for off reservation Indians, who make up approximately fifty percent of the American Indian population. In 1977, 1.4% of all U.S. child abuse reports and 1.7% of all neglect reports involved off reservation Indians, yet Indians make up 0.4% of the United States population.[5] Available evidence therefore suggests that child maltreatment is at least as frequent in American Indian communities as elsewhere.

Health professionals working in Indian communities who have rarely observed severe cases of child abuse may be misled into thinking it is rare. Reservations have low population density as compared to urgan areas where most physicians train. A physician working in a community of ten thousand would be expected to see a severe case of abuse only once per year and deaths from abuse every ten years. Rapid turnover of physicians will tend to diminish awareness of past serious cases. Abused children may present dead on arrival at hospitals. Not autopsied because of cultural disapproval, cases of abuse may be misclassified as "Sudden Infant Death Syndrome" or "diarrhea." The author reviewed medical records from 1972 through 1975 at a small Indian Health Service hospital serving six thousand people. Only one case was coded "suspected abuse." Hospital staff and Community Health Representatives were asked for names of children they suspected of being abused. Forty records were reviewed and twenty showed unequivocal evidence of serious abuse and neglect that were undiagnosed as such, including several suspicious deaths.

Why Many Health Professionals Look the Other Way

Reluctance to diagnose and report child abuse, although universal, is probably more significant in Indian communities for several important reasons. First, reporting procedures are often unclear. Although federal employee regulations (BIA, IHS) mandate reporting, the procedures are often unclear or cumbersome. Many Indian communities have not worked out which agency has primary responsibility to receive reports and conduct immediate investigations. Social services may be provided by several different agencies: Indian Health Service, Bureau of Indian Affairs, state social services and, more recently, Tribal social

services. Unclear in the past, jurisdictional responsibility for the welfare of Indian children now generally rests with tribal courts.

Reporting child abuse in some Indian communities may involve signing an affidavit, which is viewed as one person accusing another of a crime. IHS physicians are understandably reluctant to place themselves in this position. They are usually transient and they may be mistrusted as outsiders and government employees. Eager to be accepted and liked, they fear confronting the anger of families that reporting child abuse and neglect would stir up. Given a background of unrest, hospital personnel also fear that, except in the most obvious and serious cases, reporting maltreatment would be unfavorably viewed by the community.

Health professionals may be reluctant to report maltreatment, in the absence of effective protection and treatment programs. Aware of the negative consequences of reporting, health professionals may want some assurance that some good will come from reporting. Social and mental health services are in short supply and may be poorly accepted by Indian clients. The average BIA social worker's case load is in excess of one hundred families per worker. Historically, social services have dealt with maltreatment by removing children. Although the harm of such separations has been repeatedly shown, alternatives are still lacking in many, if not most, Indian communities. With little help provided to families and children, health professionals may feel justified in not reporting all but the most serious of cases. Unfortunately, without reporting, the extent of the problem will remain obscure; the impetus to deal with cases further delayed; and children with "mild injuries" may be likely to sustain repeated severe or even fatal injuries.

Children's advocates must recognize that significant barriers exist to identifying and reporting child maltreatment in many Indian communities. There are, however, hopeful signs that this is changing rapidly, as Indian people are becoming increasingly more aware and involved, and as new services begin to develop. A number of tribes have established juvenile courts, modern juvenile codes, and contracts with the BIA under the Indian Self Determination Act to establish tribal control of social services, and thus a consolidation of efforts. Child abuse and neglect are now frequently discussed by Indian people on many reservations and training sessions are occurring regularly. A National Child Abuse and Neglect Resource Center was established in Tulsa, Oklahoma in 1979.[8] Since 1978, Save the Children has held an annual Indian Child Conference, where topics relevant to child abuse, child development and parent training have been presented.[9] In a number of Indian communities, Child Advocacy Teams (or Child Protection Teams) have been established to review cases, coordinate treatment efforts and serve as an advisory group to the tribal courts. The Indian Child Welfare Act, enacted in 1978, clearly establishes that tribal courts have jurisdiction over Indian children and also provides funds for the establishment of family support programs.[3] Although Indian Health Service has adopted a modern policy on child abuse, and is developing a registry of cases, it has yet to officially designate child maltreatment as a significant cause of morbidity and mortality for Indian children and allocate training and resources apporpriate to deal with this problem. Child maltreatment continues to be a political problem, and neither the health system nor the social welfare system nor the legal system nor tribal governments

appear willing to take an assertive role from fear it will become "theirs" alone to deal with.

Causes of Indian Child Maltreatment

There is little published information on the maltreatment of Indian children. The author has collected cases and compiled the patterns described below. There are no typical or diagnostic profiles of neglectful or abusive parents. Each case must be assessed individually.

-- Child Neglect or Cultural Misunderstanding?

Certain traditional Indian practices such as "living amongst relatives" and "sibling caretaking" have been mistakenly viewed as neglectful by non-Indian health and social workers. These practices are neglectful, however, if children are moved back and forth between relatives who are unable to meet their needs. Such children show physical signs of neglect along with developmental delays and poor interpersonal skills. Young children left alone for several days or seven year old children left in charge when a reservation family moves to the city are clearly inappropriate and hazardous. It is important to look at the quality of the parent-child relationship in order to differentiate normal patterns of child rearing from neglectful ones. An Indian nurse, aid, CHR, social worker, etc. may be helpful to the non-Indian health professional seeking to differentiate such patterns.

-- Poverty

Child maltreatment is observed more commonly among the poor, probably because the stresses of poverty interfere with parenting. Yet many poor families protect and nuture their children while families that are well off may cause abuse and neglect. It is important to recognize that factors such as small living areas, lack of running water or electricity, limited parental education, large family size or the use of traditional healers may reflect traditional Indian living and are not indicators of maltreatment.

— Cultural Change with Erosion of Social Supports

As a culture undergoes "modernization", traditional family roles and supports may erode and child maltreatment may emerge. Alcoholism, depression, and suicide are prevalent problems on many reservations. When Indian families move to cities they may also lose their support system.

-- Situational Stress with Ineffective Social Supports

Many families may function reasonably well until the loss of a job, illness, death, the birth of a child or other life event produces sufficient stress to overwhelm the parents. Children at certain developmental stages may also be "more difficult" and contribute to family stress. The fussing of infants, the defiance of toddlers, or the rebellousness of adolesants are common situations when abuse may occur. Undoubtedly situational stress can be identified in most if not all cases of maltreatment; in some it is short lived, and readily responsive to intervention with a good prognosis. In others, it represents a life long pattern for the family and treatment is likely to fail.

Case Example:

A six week old Papago Indian infant was admitted with diarrhea for "social reasons." This was the third child to a young well educated Papago couple. During the pregnancy the father had a work related injury and was laid off. The stress of another baby led him to begin drinking during the last month of his wife's pregnancy. After the birth of the baby, mother had difficulties with nursing and the baby gained poorly. Her mother, who shared the household, was critical of her and her husband, especially when the baby began fussing at approximately two weeks of age. At one month the baby's fussing led to an arguement between the parents over what to do for the baby. Father slapped mother and baby, and they fell to the floor, leaving bruises. Father ran out, took an overdose of medications and was admitted to the hospital. Over several months of weekly family counseling, the family was able to be safely reunited and have done well. The issues in counseling included relief of father's guilt over causing the abuse and drinking; relief of the mother's guilt over not being able to nurse her baby or keep him from fussing; and both parents dealt with setting limits with the grandmother.

-- A Generation of Unparented Parents

As many as twenty-five to thirty-five percent present day Indian parents were raised apart from their families in

boarding schools and foster homes, where they had poor parental role models. Parenting skills are generally learned by example. Assessment of maltreatment should include attention to parents' childhood experiences. Programs to provide support and training for Indian parents who did not receive this from their families are needed. The Annual Indian Child Conference and the National Indian Resource Center on Child Abuse and Neglect have described such programs.

— Alcoholism

Fifty percent of child abuse cases and eighty percent of neglect are alcohol related, compared with twenty percent for the non-Indian population. Dysfunctional Indian families are likely to turn to drinking when problems become overwhelming. Alcohol lowers the threshold for violence and makes parents less responsive to children's needs. Mothers who ingest moderate amounts of alcohol (2 drinks per day) during pregnancy may produce children with fetal alcohol syndrome, which some view as abuse of the unborn child. The incidence of fetal alcohol syndrome ranges from one in sixty to one in four hundred fifty live births for Indian children, compared to one in six hundred live births for the general U.S. population.[10] There are many patterns of Indian drinking with very different effects upon children. In some cases, severe family disintegration has occurred in multiple generations including the extended family, with children showing many signs of chronic neglect. In such families treatment is likely to fail, and the only hope for such children is to place them with a suitable Indian adoptive family. In other families, functioning may be good between episodes of binge drinking. Even if parental drinking behavior cannot be modified, the effect upon children can be mitigated. Encouragement and support can be given to extended families to provide temporary child shelter or to communities to develop foster care networks or crisis nurseries to assure appropriate child care during drinking episodes. One alcohol treatment program in a Pueblo community developed a traditional dance troupe for children of alcoholic parents, providing them with role models and support.

Case Example:

Twins were born to a sixteen year old unwed Apache girl whose father died one year earlier in an alcohol-related auto accident. Shortly after his death, her mother began drinking, and became unavailable to help her with the pregnancy and birth of the twins. Within the first year of life, each twin was admitted numerous times with nonorganic

failure to thrive and recurrent illnesses including diarrhea and dehydration, otitis media, and bacterial meningitis in one twin and septic arthritis in the other. Their development was also delayed. The young mother appeared caring but immature and overwhelmed, and the children were placed in foster care. With the help of a social worker and a medicine man, the maternal grandmother resolved her grief over her husband's death, stopped drinking and reassumed the role of head of the family. The twins were returned, and dramatically their growth, development and health improved, and their mother was able to finish high school.

— Divorce

In cases of divorce, anger between the parents may be projected onto the children, and some children may be physically or emotionally abused. More often, however, children without injuries are alledged by one parent to have been abused by the other parent, as a means of keeping custody battles open. Such cases dramatize the importance of independent legal representation for children.

— Unusual Perceptions of Children: Psychosis or Mythology?

Psychotic parents may have very distorted perceptions of their children and such children, if they are involved in the delusional system of their parents, are felt to be in great danger. Overall, psychotic or sociopathic parents are found in less than ten percent of reported maltreatment cases. Sometimes Indian mythology may ascribe evil properties to children.[15]

Case Example:

Rachel, a three year old Apache child was left by her twenty year old mother with cousins. These cousins, a couple in their twenties were college educated and model parents of three young boys. They had always wanted a girl and understood that Rachel would live with them from then on. Things went well for about six months and then Rachel's mother wrote that she was coming to take Rachel back. This caused the cousins great distress. They began to see Rachel as possessing evil properties. They stated that she would fondle the genitals of animals, eat their excrement, use obscene language, refuse to eat normal food or interact normally. Hence, they did not feed her, they shaved her head and isolated her from the family. They wrote to Rachel's mother telling her to pick Rachel up or she would soon be dead. The mother arrived to find her in a desperate state: dehydrated, covered with bruises and

sores and severely malnourished. When recovered, Rachel appeared fearful, but was developmentally and behaviorally normal. Following this incident there was harsh disapproval by the community towards the cousins and they moved off the reservation for several years. No criminal charges were filed. Their care of their three boys appeared excellent and family functioning appeared adequate. Rachel was returned to the custody of her mother.

Understanding folklore as it relates to child rearing behavior may be important in the assessment and management of maltreatment in some Indian families, although this information is not readily accessible to outsiders. The use of traditional healers may be important as a treatment modality for some cases. The non-Indian physician will need guidance from local Indian people in the assessment and management of such cases.

-- Children with Handicaps

Children with congenital or acquired handicaps pose unique stresses to parents and caretakers. When added to other stresses, they may prove too great to bear. Parents of a handicapped child normally experience grief which includes feeling angry. Parents may feel inadequate or incompetent because they have produced a defective child. There may be a wish to get rid of the child to end his and their misery. Sometimes these feelings are acted upon and lead to abuse. Handicaps may also have symbolic significance reflecting the parents' violation of a taboo. Sometimes handicapped children are kept at home shrouded in shame and secrecy. One severely retarded Apache boy came to attention at eighteen years of age after having been kept at home secretly, chained to a bed for years, in the family's belief that this was best for the child. In a young Mexican-Indian child with cerebral palsy, feeding difficulties caused such great demands upon the mother's time that the father responded to its cries one night by giving the baby a black eye, jealous of the attention his wife was showing the baby.

-- Sexual Abuse

In the last few years a surge of reported sexual abuse cases has been seen nationally; approximately fifteen percent of reported abuse involves sexual abuse, usually between father or step-father and daughter. Twenty percent of college students report a sexually traumatizing experience during childhood.[16] A similar rise in sexual abuse cases is being seen in Indian communities, but little is know about frequency, characteristics or family dynamics.

All Indian cultures appear to have strong sanctions against incest, which usually includes not only sexual relations with the immediate family, but also within the entire clan. A variety of physical and psychological symptoms (including suicide and psychotic behaviors) are ascribed to incest. Levy has found that Navajo's believe that epilepsy is caused by violation of the taboo against incest. He found that thirty percent of Navajo epileptics had experienced incest, although he believes this represents a self-fulfilling prophecy, as the onset of seizures preceeded the incest in most cases.[17] In a number of Indian cultures, the victim of sexual abuse may suffer symptoms and ostracism. The author encountered a five year old Apache girl with gonorrhea, acquired from relations with a fifteen year old cousin. Upon hearing of this incident, the child's father brutally beat her. The boy was jailed.

Sexual abuse evokes very strong feelings in health professionals, community members and in families, where it can lead to violence, especially during disclosure. During a consultation visit to a Plains reservation, the author heard repeatedly about a troubling case of suspected incest, but the doctor, public health nurse and Indian community health representative lived in fear of reporting in the absence of "proof". When their collective information was pooled, the evidence was overwhelming; their fear occurred because the case involved the tribal judge's daughter. The case was reported to state social service. Another case on the Navajo reservation involved a ten year old girl who reported sexual intercourse with her step-father and whose exam demonstrated sperm in the vagina. Following confrontation of the father, he pulled a shotgun from his pick-up and threatened to kill himself and his family.

Sally is a ten-year-old Navajo girl who was brought up to the Emergency Room with complaints of vomiting, fever, abdominal pain, burning on urination and vaginal itching with discharge. There were no bruises or other signs of injury. Physical exam was normal except for vaginal irritation and itch, which upon microscopic exam, showed pus and gram negative introcellular diplococci, typically of gonorrhea. While in the hospital, Sally stated that, "my mother bothers me like the doctor did", (referring to obtaining the vaginal smear). She reports this has been happening on a regular basis since age five. She has asked her mother to stop and has told her father, but he has said not to bother him with this problem. Sally says her mother touches her with her fingers and indicates that the fingers enter the vagina. Sally denies anyone else has touched her or hurt her.

> Following admission, BIA social services was asked to investigate. On the third hospital day, Sally was feeling fine and her parents threatened to remove her, "against medical advice". The physician reluctantly discharged Sally with the assurance from BIA that they had established contact and would follow-up after discharge. Follow-up has met a dead-end for almost one year. Attempts at family evaluation have been met with total resistance by the family. Sally has subsequently denied her previous allegations. She is currently failing in school. Repeated efforts by the doctor to get the case heard in court have been unsuccessful. At present there is no active follow-up on Sally or the family.

How Harmful is Maltreatment?

Information on maltreated, non-Indian children indicates that approximately 0.5% of maltreated children die and a similar number are permanently disabled as a result of their injuries.[5] Approximately twenty-five percent of maltreated children show permanent growth deficiency and other physical problems. Approximately sixty percent of maltreated children show significant developmental delays in cognition (intelligence), language, and social development, including some with withdrawn behaviors and others with aggressive behaviors.[11] Retrospective studies of prostitutes, violent criminals, substance abusers, child abusers, juvenile deliquents, teenage runaways, and institutionalized mentally retarded and mentally ill adults reveal a substantial percentage that were abused or neglected as children. While similar data are not available for Indians, the author has frequently observed that Indian alcoholics, juvenile delinquents and criminals often report abuse and neglect in childhood.

How Effective is "Treatment?"

A large study of the effectiveness of protective service intervention yielded disappointing results. Treatment included parent training,

homemaker aides, social case workers, daycare and counseling. Despite such treatment thirty percent of children were severely re-abused and fifty-eight percent of families were judged no less likely to abuse their children after treatment.[11] Clearly more effective strategies are needed and further research on various approaches are needed, particularly in the Indian community where much less is known.

How Risky is Treatment?

Treatment of abuse and neglect often involves intrusion upon a family's privacy and may involve significant risks to children's development, particularly if it includes separation of children from the family and repeated placements. Studies of the long-term outcome of maltreated children show that those with frequent placements do more poorly compared to children with few placements. While information related to the stability and duration of foster care are not available for Indian children, data suggests that foster care is frequently interminable and unstable. In Arizona in 1980, the typical foster child spent an average of three years in foster care and endured over five placements each. A New York study of over six hundred foster children found that after five years half of them were still in foster care, unvisited by their parents. Foster care is often essential to ensure protection of the maltreated child in a home-like environment, while treatment efforts for the family are instituted. Careful recruitment of foster families, with follow-up of each child's adjustment to the particular foster home along with frequent re-evaluations of the need for continued foster care are essential.

Balancing of Risks: Finding the Happy Ending

In order to arrive at a good long-term outcome for maltreated children and to avoid the hazards of treatment, each case must be assessed individually. Treatments should be tailored to each child's and family's needs. The following table indicates the key questions to be addressed and the assessment strategies utilized by the interdisciplinary child advocacy team or the agents responsible for case management. (Table II)

There are two possible happy endings to cases of child maltreatment: either the family is rehabilitated and the child can be safety returned, with reduced risk of further maltreatment. This can be anticipated in over ninety percent of cases. When the child's injuries are chronic and severe, and when efforts to rehabilitate families have failed, the second happy ending can be achieved if the child is promptly freed for adoption into a family that can meet his or her needs. Experience has shown that suitable Indian foster and adoptive families can be found for children who will ultimately be adopted;[12] the biggest problem is the long delay before such cases are decided. During this time children may suffer repeated trauma, from unstable foster placements, from repeated treatment failures, and from lengthy legal procedures. For an infant who has been severely abused and whose parents have failed treatment, it commonly takes two to four years to free him for adoption. This interval is far too long if such a child is to have a reasonable chance of normal development. Strong legal leverage, the use of treatment contracts, frequent evaluations of progress, and early decisions are needed. It can usually be determined whether a family will respond to treatment or not

within three to nine months. Encouragement of voluntary relinquishment is also needed when parents do not make progress. Voluntary relinquishment frees children for adoption much faster and gives parents input into planning for their children's long-term needs. Even grossly inadequate parents usually care about their children's welfare.

The Role of the Health Professional

It is important that health professionals gain a broad view of the problem of child maltreatment, its clinical presentation, the range of therapeutic services available, and the legal ramifications. The non-Indian health professional must also realize the political implications of his/her role as an outsider. Finally the professional must come to terms with his/her own feelings concerning cases of maltreatment and use the support of colleagues to diffuse anger that may otherwise interfere with treatment if directed at families or colleagues in other agencies.

The health professional has an important role in providing medical expertise and in supporting community development efforts. It is perhaps most helpful to conceptualize the health professional's role in terms of three levels of prevention. Primary prevention refers to efforts to prevent maltreatment before it occurs. The thrust of such intervention is in providing education to prevent unwanted pregnancy, to enhance parental adjustment to pregnancy and parenthood, and to facilitate parent/child attachment. Interventions include participating in community health education efforts, providing family planning information, and attending to parent/child issues in pre natal, perinatal, and well child care. During the perinatal period, mothers

should be encouraged to have a supportive companion present during labor, to room in with her infant, to breastfeed and to receive information on the developmental capabilities of infants. During well child care, attention to parental adjustment, provision of supportive home visitors, such as public health nurses or CHR's, education in the normal development of infants and children especially concerning infant fussing, toddler defiance, and adolescent rebellion, developmental stages correlated with abuse.[13]

Secondary prevention refers to efforts to detect maltreated children early, with the provision of interventions designed to prevent serious re-injury or developmental or behavioral problems. The health professional must be alert to the modes of clinical presentation of child maltreatment. In particular, the health professional should suspect maltreatment when children present with trauma, poisoning, failure to thrive, genital injuries, venereal disease or developmental and behavioral problems. The health professional should identify consultants in child abuse and child development, who are usually present in academic or regional pediatric centers, and who can be called upon to assist in the assessment of difficult cases. When a child's history is inconsistent with observed physical findings or when for other reasons maltreatment is suspected, the health professional must report suspected cases to local agencies mandated to receive reports. Reporting procedures should be included in orientation of new health professionals and be posted in appropriate places in clinics and emergency rooms. Parents should be informed of the legal requirements to report and told in a non-threatening and supportive manner of the nature of the

investigation that will follow. The health professional should follow verbal reporting with a brief written report, using laymen's language to summarize the clinical history, the physical findings, and the clinician's reasons for suspecting maltreatment.[14]

Tertiary prevention refers to intervention during the late stages of a disease, in order to minimize its handicapping effects. With child maltreatment this translates into providing close medical followup of a child's injuries and ensuring that appropriate assessment of the child's development and behavior, family function, and parent/child interaction occur. Additionally, the health professional may provide very useful input into multidisciplinary child advocacy teams that coordinate treatment efforts. For children placed in foster care medical follow-up should include attention to the child's physical problems as well as emotional adjustment to the foster family. The health professional can also play an important role in helping parents with health or psychological problems that interfere with parenting to obtain appropriate treatment, and help them face relinquishment if treatment has failed.

Health professionals can also play effective roles as supporters of local community treatment efforts, by serving on the boards of crisis nurseries, preschools, parent training programs, etc. and assisting in community efforts to improve public awareness and by writing grants to obtain funds for new treatment services. In all these efforts, the health professional should work cooperatively with workers in other agencies and be supportive of Indian families and Indian people, who are ultimately responsible for the welfare of Indian children.

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TABLE I

SPECTRUM OF CHILD MALTREATMENT

-Deviant childrearing by child's caretakers resulting in harm to the child that is non-accidental.

Abuse: Act of commission with/or without intent to harm child.

-Physical Abuse: Welts, lacerations, burns, fractures, CNS, and internal injuries, etc.

-Sexual Abuse: Incest, molestation, rape, etc.

-Emotional Abuse: Degradation; schizophrenic parent with evident emotional disturbance in child.

-Chemical Abuse: Intentional poisoning.

Neglect: Act of omission with/or without intent to harm child.

-Physical Neglect: Failure to provide basic care and protection, shelter, warmth.

-Nutritional Neglect: Non-organic failure to thrive (underfeeding).

-Supervision Neglect: Young children left alone.

-Medical Neglect: Lack of basic medical care, when the failure to receive care will likely result in harm to the child.

-Emotional Neglect: Lack of stimulation with evident developmental delays.

TABLE II

OVERVIEW OF ISSUES IN CASE MANAGEMENT AND FOLLOW-UP

Key Questions	Assessment Strategies
1) What harm has the child sustained?	1) Medical assessment: (hx, physical exam and developmental screening). Developmental Screening: DDST with behavioral observations for preschoolers; school report for older children. If screening abnormal, refer for diagnostic assessment to regional developmental center or school, psychologist, speech pathologist, audiologist, etc.
2) Can the child's safety be assured?	2) Determination by social worker or team based on #1 plus family assessment with home visit. Family assessment should include demographic info, life events, supports, health history, early childhood hitory and observation of parent/child interactions. Some families may need psychological/ psychiatric evaluation.
3) What are the child's needs? What are his/her strengths and limitations?	3) A synthesis of diagnostic findings from 1 and 2 above.
4) To what extent can the family meet the child's needs? What are the family's strengths and limitations?	4) A synthesis of diagnostic findings based on 1 and 2 above.

TABLE II (continued)

OVERVIEW OF ISSUES IN CASE MANAGEMENT AND FOLLOW-UP

Key Questions	Assessment Strategies
5) What is the most appropriate treatment? For child? For family? What resources are available?	5) Social worker (with input from the team) develops treatment contract that is specific and realistic and appropriately sequenced - obtains parent input and agreement with contract. Determines who will provide services and follow-up, involving as few different people as possible, so as not to overwhelm family.
6) How and when will progress be evaluated and decisions made?	6) Staff conference to report progress. Prior to conference, obtain report from physicians, schools, mental health or other treatment providers. Case manager uses this information to go to court, if needed.